IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
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September 3, 2008

Russell McCoy
South Bannock Group Home
415 South Arthur
Pocatello, ID 83204-3317

RE: South Bannock Group Home, Provider #13G015

Dear Mr. McCoy:

This is to advise you of the findings of the Medicaid/Licensure survey of South Bannock Group Home, which was conducted on August 28, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 16, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by September 16, 2008. If a request for informal dispute resolution is received after September 16, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

DEVELOPMENTAL OPTIONS
PROMOTING FUNCTIONAL INDEPENDENCE THROUGH PERSON-CENTERED SERVICES

September 16, 2008

Ms. Nicole Wisenor, Supervisor
Non-Long Term Care
Department of Health and Welfare
Division of Medicaid
Bureau of Facility Standards
P. O. Box 83720
Boise, ID 83720-0036

Dear Ms. Wisenor:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for South Bannock Group Home from the survey completed August 28, 2008. On the Statement of Deficiencies / Plan of Correction, Form HCFA-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed above.

Sincerely,

Russell C. McCoy, M.A. Ed.
Executive Director

Enclosures

Russell C. McCoy, Executive Director • rmccoy@ida.net
415 South Arthur • Pocatello, Idaho 83204 • Phone (208) 233-6833 • Fax (208) 233-6842 • doptions@ida.net • www.developmentaloptions.com

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G015	A. BUILDING _____ B. WING _____	08/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BANNOCK GROUP HOME	3875 SOUTH BANNOCK HIGHWAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Leader Michael Case, LSW, QMRP Common abbreviations used in this report are: ATS - Active Treatment Specialist IPP - Individual Program Plan LPN - Licensed Practical Nurse QMRP - Qualified Mental Retardation Professional	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure each individual's need for guardianship was addressed for 1 of 4 individuals (Individual #4) whose IPPs were reviewed. Failure to obtain guardianship did not ensure the individual's rights were protected. The findings include: 1. Individual #4's 1/29/08 IPP stated he was a 45 year old male whose diagnoses included profound mental retardation, generalized anxiety disorder, and autism. Under the Human Rights Assessment section of the IPP it stated	W 125	**W125 483.420(a)(3)** For Individual #4 the facility will actively pursue guardianship on a quarterly basis with any identified family or friends of the individual. There are no other individuals affected by this deficiency as all of the other individuals currently have legal guardians. A form will be created by the Residential Program Director that will track the facility's efforts in obtaining guardianship. Corrective Action Completion Date: October 27, 2008 Person Responsible: Jamie L. Anthony, Residential Program Director RECEIVED SEP 18 2008 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Acting Director	09/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 125	Continued From page 1 "[Individual #4] received a human rights assessment on January 24, 2007. He did not understand any of his rights listed in the assessment." Individual #4's Human Rights Committee approval form, dated 6/19/08, stated his restrictive interventions included the use of Zyprexa (an antipsychotic drug) 7.5 mg per day, Depakote ER (an anticonvulsant drug) 500 mg per day, Lexapro (an antidepressant drug) 10 mg per day, and Trazodone (an antidepressant drug) 25 mg per day for agitation. Additionally, the form included the use of a "Wake-Up Schedule," defined as waking Individual #4 at 2:00 a.m. to toilet, and "Head Support for Resistance to Oral Care," defined as standing behind Individual #4 while using one arm to hold his head gently against the staff's body, cupping his chin with their hand, then using their other hand to brush Individual #4's teeth. When asked during an interview on 8/28/08 from 11:10 - 11:55 a.m., the QMRP stated the family is asked about guardianship yearly but has not followed through with obtaining guardianship. The QMRP stated she had sent documentation to the family regarding guardianship, but was unable to provide information the facility had actively pursued guardianship for Individual #4 other than a yearly request of the family. The facility failed to ensure guardianship was being actively pursued for Individual #4.	W 125		
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water,	W 426	**W426 483.470(d)(3)** The water temperatures were corrected before the end of this survey. To ensure that the water temperatures remain within	

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W 426	Continued From page 2 ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 8 of 8 individuals (Individuals #1 - #8) who were unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include: 1. Hot water temperatures were obtained at the facility during an environmental review on 8/27/08 from 10:30 - 11:00 a.m. and were recorded as follows: Kitchen sink - 113.0 degrees Fahrenheit Laundry room bathroom - 114.1 degrees Farenheit Tub bathroom - 117.0 degrees Farenheit Shower bathroom - 115.9 degrees Farenheit When asked if the individuals residing in the facility could regulate the water temperature, the ATS who was present stated they could not. At that time, the ATS was notified of the water temperatures being too high. The facility failed to ensure water temperatures were maintained at or below 110 degrees Fahrenheit. The water temperatures were again tested on 8/28/08 at 10:30 a.m. and found to be within the acceptable range.	W 426	acceptable range, the Active Treatment Specialist will check these temperatures on a weekly basis and document this on the Weekly Home Inspection. Any discrepancies will be reported to the maintenance department so correction can be made. The grave yard staff also check the water temperatures each morning (at approximately 5:00 am) and document these numbers on the water temperature form. Corrective Action Completion Date: September 1, 2008 Person Responsible: Christina Zuasch, Active Treatment Specialist	

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W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control communicable diseases. This directly impacted 4 of 6 individuals (Individuals #2, #3, #5, and #7) observed during a medication pass, and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility by providing opportunities for cross-contamination to occur between individuals and negatively impact their health. The findings include: 1. During an observation on 8/26/08 from 6:20 - 8:30 a.m., the following infection control issues were noted during the medication pass: - At 7:23 a.m., a staff came into the office where medications were being passed, removed cotton balls from a bag in the medication cabinet, dropped no less than 4 cotton balls on the floor, picked up the dropped cotton balls and returned them to the bag in the medication cabinet. - At 7:25 a.m., the staff conducting the mediation pass was noted to lick the index and middle fingers on her right hand, turn a page in the medication book with those fingers, then picked up a medication cup by inserting the finger she had licked inside the medication cup. The staff then assisted Individual #2 to dump his medications from a mediset (a daily dose medication container filled by the pharmacy) into	W 455	**W455 (483.470(l)(1)** The Lead LPN issued a memo to the staff regarding infection control procedures. The Active Treatment Specialist will conduct on-going staff training regarding infection control via observations and written information on a quarterly basis. Staff observations and written information will be documented on a form created by the Residential Program Director. Corrective Action Completion Date: October 27, 2008 Person(s) Responsible: Jamie L. Anthony, Residential Program Director and Christina Zausch, Active Treatment Specialist	

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W 455	Continued From page 4 the medication cup. - At 7:45 a.m., the staff conducting the medication pass was noted to lick the index and middle fingers on her right hand and turn the pages in the medication book. Individual #5 entered the office where medications were being passed. The staff conducting the medication pass completed the medication pass procedure, including hand over hand assistance to dump Individual #5's medications from the mediset to a mediation cup. Staff were not noted to wash or sanitize Individual #5's hands at any time during the medication pass. The staff had not been noted to wash or sanitize her own hands since licking her fingers at 7:45 a.m. - At 7:55 a.m., Individual #7 entered the office where medications were being passed. Staff assisted Individual #7 to dump his medications from a mediset into a medication cup. Staff were not noted to wash or sanitize Individual #7's hands at any time during the medication pass. The staff had not been noted to wash or sanitize her own hands since licking her fingers at 7:45 a.m. - At 8:05 a.m., Individual #3 entered the office where medications were being passed. The staff conducting the medication pass used hand sanitizer on her own hands, then used hand sanitizer on Individual #3's hands. The staff was then noted to scratch her head multiple times with her right hand. After assisting Individual #3 to dump her medications from a mediset into a medication cup, the staff dumped Individual #3's pills into her bare left hand, then used her right hand to touch the pills while identifying them and counting them for Individual #3. Staff returned	W 455		

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W 455	Continued From page 5 the pills to the medication cup, dumped the pills into her bare left hand, used her bare right hand to remove 9 Depakote (an anticonvulsant drug) sprinkle capsules, used her bare hands to open the capsules and dump them into a second medication cup. The staff picked up a plastic spoon by the bowl of the spoon with her bare right hand. The staff repeatedly ran the fingers of her right hand through her hair, and then assisted Individual #3 to scoop her pills from the cup with the spoon. At 8:25 a.m., the ATS, who was present during the observation, and the staff conducting the medication pass were asked about training regarding infection control. Both stated they had been trained regarding hand washing and sanitation, as well as on when to complete handwashing and sanitation. The staff conducting the medication pass stated what was witnessed during the medication pass was not acceptable practice. During an interview on 8/28/08 from 11:10 - 11:55 a.m., the LPN stated all staff had been trained on infection control issues, and that what was witnessed during the medication pass was not acceptable practice. The facility failed to ensure that proper infection control procedures were followed.	W 455		

Bureau of Facility Standards

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MM168	16.11.03.075.07(a) Rights as a Citizen Rights as a citizen refer to all the rights of citizens of this country and any particular state or locality. These include, but are not limited to, voting, marriage, divorce, executing instruments (e.g., wills), acquiring and disposing of property, and choosing to practice or not practice a religion. This Rule is not met as evidenced by: Refer to W125.	MM168	**MM168 16.11.03.075.07(a)** Please refer to W125	
MM266	16.03.11.100.03(a) Garbage Containers All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material and shall not leak or absorb liquids. Containers must be provided with tight-fitting lids. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all containers used for storage of garbage and refuse were provided with tight-fitting lids for 8 of 8 individuals (Individuals #1 - 8) residing in the facility. The findings include: 1. An environmental review was conducted on 8/27/08 from 10:30 - 11:00 a.m. During that time it was noted there were no lids on the garbage cans in the bathroom with the tub, the bathroom with the shower, or the bathroom next to the laundry room. The ATS, who was present during the review, stated the lids were sometimes removed for cleaning and staff must have forgotten to replace the lids. The ATS attempted to locate the lids but was unable to do so. The facility failed to ensure garbage cans in the bathrooms used by individuals residing in the facility were provided with tight-fitting lids.	MM266	**MM266 16.03.11.100.03(a)** The garbage containers have been provided with tight-fitting lids. To ensure this deficiency does not occur again, the facility will add this to the Weekly Home Inspection which the Active Treatment Specialist will complete. Corrective Action Completion Date: October 27, 2008 Person Responsible: Christina Zuasch, Active Treatment Specialist RECEIVED SEP 18 2008 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 09/16/08

Bureau of Facility Standards

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MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include: 1. An environmental review was conducted on 8/27/08 from 10:30 - 11:00 a.m. At that time, the following chemicals were found in an unlocked cabinet above the washing machine: - A bottle of generic all purpose spray cleaner with bleach. - A bottle of Lysol disinfectant spray cleaner. The following chemicals were found in an unlocked cabinet beside the washing machine: - A bottle of Mr. Clean liquid cleaner. - A bottle of generic all purpose spray cleaner with bleach. The ATS, who was present during the review, stated the items should have been locked. The ATS placed all the items in the lower cabinet next to the washer, removed a padlock from the cabinet, closed the cabinet and applied the lock. The facility failed to ensure all toxic chemicals were stored in appropriate areas under lock and key.	MM271	**MM271 16.03.11.100.04(b)** All toxic chemicals have been properly locked in the cabinet located in the garage of the facility. To ensure staff locks all toxic chemicals after each use, training will be conducted once each quarter on this requirement. Training will be conducted in the staff meeting by the Active Treatment Specialist. Corrective Action Completion Date: October 15, 2008 Person Responsible: Christina Zuasch, Active Treatment Specialist	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility	MM380	**MM380 16.03.11.120.03(a)** Metal Trim – The metal trim was repaired immediately upon discovery.	

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MM380	Continued From page 2 rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include: During an environmental survey conducted on 8/27/08 from 10:30 - 11:00 a.m., the following concerns were noted: - The metal trim to the left side of the garage door was bent away from the building leaving a sharp edge sticking out approximately 8 inches above the ground beside the front walk. - The wooden threshold for the back door leading from the living room to the back yard was missing it's finish creating an un-cleanable surface. - The carpet by the back door was wrinkled where it butted up to the threshold creating a trip hazard. - There was an 8 inch by 4 inch hole in the back yard by the gate. - The white dresser for Individual #7 had a brown stain on the bottom drawer and a blue gel like substance on the top. The dresser also had rust stains on it. - The tub bathroom had a sink that was slow to drain.	MM380	Corrective Action Completion Date: September 3, 2008. Person Responsible: Sam Guyette, Physical Facilities Manager. Wooden Threshold – The threshold was replaced and will be refinished. Corrective Action Completion Date: September 12, 2008. Person Responsible: Sam Guyette, Physical Facilities Manager. Carpet – The carpet has been glued back down. Corrective Action Completion Date: September 12, 2008. Person Responsible: Sam Guyette, Physical Facilities Manager. Hole in yard by gate – The hole has been filled. Corrective Action Completion Date: October 27, 2008. Person Responsible: Sam Guyette, Physical Facilities Manager. Dresser – The dresser has been replaced. Corrective Action Completion Date: September 11, 2008. Person Responsible: Jamie Anthony, Residential Program Director. Tub bathroom sink – The sink has been cleared. Corrective Action Completion Date: September 5, 2008. Person Responsible: Sam Guyette, Physical Facilities Manager.	

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MM380	Continued From page 3 - There was a 3 foot by 2 inch stain on the carpet in front of Individual #3's closet.	MM380	Stain on carpet – An additional carpet cleaning will be done and a hand-help carpet cleaner will be purchased for the home. Corrective Action Completion Date: October 31, 2008. Person Responsible: Jamie Anthony, Residential Program Director.	
MM696	16.03.11.250.09(d)(i) Refrigerator and Freezer Each refrigerator and freezer must be equipped with a reliable, easily read thermometer. Refrigerators must be maintained at forty-five (45) degrees Fahrenheit or below. Freezers must be maintained at zero degrees - ten (0-10) degrees Fahrenheit or below. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the refrigerator temperature was maintained at 45 degrees Fahrenheit or below for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include: 1. An environmental review was conducted on 8/27/08 from 10:30 - 11:00 a.m. During that time the thermometer in the kitchen refrigerator indicated the temperature was 52 degrees Fahrenheit. The refrigerator contained miscellaneous food items that required refrigeration including milk, yogurt, cottage cheese, cream cheese, and lunch meats. The ATS, who was present during the review, stated she would contact the maintenance person to adjust the refrigerator as the control knob had been removed. During a follow up review, on 8/28/08 from 10:25 - 10:30 a.m., the thermometer in the kitchen refrigerator indicated the temperature was 42 degrees Fahrenheit. The facility failed to ensure the refrigerator temperature was maintained at 45 degrees Fahrenheit or below.	MM696	**MM696 16.03.11.250.09(d)(i)** The refrigerators will be inspected on a weekly basis and the temperature recorded. If the recorded temperature is above 42 degrees, an adjustment will be made with a follow-up check and data recording 4 hours later. Corrective Action Completion Date: October 27, 2008. Person Responsible: Stephen Pippenger, Food Service Supervisor.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G015	A. BUILDING _____ B. WING _____	08/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BANNOCK GROUP HOME	3875 SOUTH BANNOCK HIGHWAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	**MM769 16.03.11.270.03(c)(vi)** Please refer to W455	